Authorization for Release of Protected Health Information (PHI)
to
The Office of Financial Management (OFM) Risk Management Division

Name: _____
(Last, First, Middle Initial or Middle Name)

Date of Birth: Month _____ Day ____ Year _____

I hereby authorize disclosure of my protected health information to the Office of Financial Management, Risk Management Division, for purposes of processing my claim for damages filed with the State of Washington.

I understand that by signing this document, I authorize the release of the following information:

Complete medical record for all services, including history and physical exam; progress notes; x-ray reports; inpatient admissions; operative notes; physical or other therapy; laboratory and other test reports; physician and physician assistant orders; nursing notes; and all other records and references designated by the provider as part of its medical record.

HIV Test Results and medical information related to HIV testing or treatment

Psychiatric, mental and behavioral health records, including treatment notes, assessments, testing documents and results, and medical records related to mental health diagnosis and treatment

Alcohol assessment, testing, referral or treatment records

All other chemical dependency assessment of treatment records

Pharmacy prescriptions and reports

All letters and memos received or sent, including electronic mail, referencing my treatment, compliance with treatment and any other subject related to my medical treatment

Information related to alleged sexual assault or sexually transmitted disease, including test results

Urgent care, outpatient or other clinic visit information

Gynecological and/or obstetrical information

All client records generated for or by governmental programs of which I am a client. Identify the program(s) and agency: _____.

Financial records related to my care and treatment

I understand the following: **(PLEASE READ AND INITIAL ALL STATEMENTS)**

_____ Initials I understand that my records are protected under HIPAA/PHI regulations (federal law) and the Washington State Health Care Information Act (RCW 70.02).

_____ Initials I understand that my health information may be subject to re-disclosure by OFM and not protected for purposes of evaluating and investigating the claim I have filed with the State of Washington.

_____ Initials I understand that the specific information to be disclosed in my medical record may include information regarding alcohol, drug or other controlled substance use, counseling referrals and/or a history of testing or treatment of acquired immune deficiency syndrome.

_____ Initials I understand that I may revoke this authorization at any time by notifying OFM in writing, and that the revocation will be effective as of the date OFM receives it. Any records obtained pursuant to this Authorization for Release of PHI prior to the revocation will be deemed authorized by me for release.

_____ Initials I understand that this Authorization for Release will expire 90 days from the date I sign it. I can also authorize a different time frame for this release to be valid. I authorize this permission to be valid until my claim is resolved or closed by OFM.

A Photostat of this Authorization carries the same authority as the original for purposes of releasing my records to OFM.

Signature of Authorizing Individual:

_____

Date of Signature: _____

Telephone number: _____

Witness (where patient is over 13 and signing the release):

_____

Where the signer is not the subject of the records:

I am authorized to sign this because I am the (attach proof of authority):

- ❑ Parent of minor
- ❑ Legal Guardian
- ❑ Personal Representative
- ❑ Other

To the Provider or Records Custodian:

Please send legible copies of all records to:

Office of Financial Management
Risk Management Division
300 General Administration Building
P.O. Box 41027
Olympia, WA 98504-1027